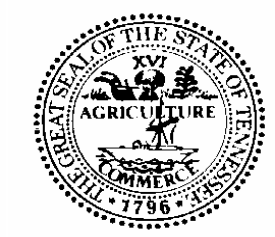

STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

and

THE OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

of

UNISON HEALTH PLAN OF TENNESSEE, INC.

(formerly known as Better Health Plans, Inc.)

MEMPHIS, TENNESSEE

FOR THE PERIOD JANUARY 1, 2005
THROUGH JUNE 30, 2005

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CC: Dave Goetz, Commissioner
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FROM: Gregory Hawkins, CPA, TennCare Examinations Manager
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DATE: March 24, 2006

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of Unison Health Plan of Tennessee, Inc. (formerly known as Better Health Plans, Inc.) Memphis, Tennessee, was completed November 4, 2005. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a market conduct examination "by test" of the claims processing system of Unison Health Plan of Tennessee, Inc. (Unison). Further, this report reflects the results of a limited scope examination of financial statement account balances as reported by Unison. This report also reflects the results of a compliance examination of Unison's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of Unison was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authority of Section 3-6. of the Contractor Risk Agreement (CRA) between the State of Tennessee and Unison, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-215 and § 56-32-232.

Unison is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of Unison. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statement as reported by Unison on its National Association of Insurance Commissioners (NAIC) quarterly statement for the period ended June 30, 2005, and the Medical Fund Target Report filed by Unison as of June 30, 2005.

The limited scope compliance examination focused on Unison's provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with non-discrimination reporting requirements, and the Insurance Holding Company Act.

Fieldwork was performed using records provided by Unison before and during the onsite examination of records, at the Memphis, Tennessee office from September 26 through September 29, 2005, and the Monroeville, Pennsylvania, office from October 31 through November 4, 2005.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that Unison's TennCare operations were administered in accordance with the CRA and state statutes and regulations concerning HMO operations, thus reasonably assuring that the Unison TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether Unison met certain contractual obligations under the CRA and whether Unison was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. § 56-32-201 *et seq*.;

- Determine whether Unison had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether Unison properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether Unison had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether Unison had corrected deficiencies outlined in prior examinations of Unison conducted by TDCI and the Comptroller.

III. PROFILE

A. Administrative Organization

Better Health Plans, Inc. (BHP) was chartered in the State of Tennessee on August 9, 2000, for the purpose of providing managed health care services to individuals participating in the State's TennCare Program. BHP is a wholly owned subsidiary of Three Rivers Holdings, Inc. (TRH). On June 24, 2005, the Secretary of State certified the Articles of Amendment to the Charter of BHP which changed its name to Unison Health Plan of Tennessee, Inc. (Unison). On August 15, 2005, BHP requested a modification to its Certificate of Authority to reflect the new corporate name (Unison Health Plan of Tennessee, Inc.). On September 1, 2005, TDCI granted this modification with an effective date of June 24, 2005.

Unison contracts with Three Rivers Administrative Services, LLC (TRAS) to provide management services. TRAS is also a wholly owned subsidiary of TRH. On August 1, 2005, TRAS also changed its name to Unison Administrative Services, LLC (UAS). The management agreement provides that all expenses to administer the terms of the CRA shall be paid by UAS. The administrative expenses include, but are not limited to, claims payments; medical management; utilization review; member services; accounting and reporting; credentialing; facilities management and mail handling; information technology management; marketing; data analysis and reporting; and, general administrative services.

The officers and board of directors for Unison at June 30, 2005, were as follows:

Officers for Unison

John P. Blank, M.D., Chief Executive Officer/President
David W. Thomas, Secretary/V.P. & Gen. Counsel/Asst. Treasurer
Leslie A. Gelpi, Treasurer/V.P. Finance/Asst. Secretary
Matthew G. Moore, V.P. & Executive Director

Board of Directors for Unison

John P. Blank, M.D. William H. Lawson, Jr. John H. Dobbs, Jr.

B. Brief Overview

Effective July 1, 2002, the CRA with Unison was amended for Unison to temporarily operate under a non-risk agreement. This period, otherwise known as the "stabilization period," was established to allow all MCOs a satisfactory period of time to establish financial stability, maintain continuity of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. Unison agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During stabilization, Unison receives from the TennCare Bureau a monthly fixed administrative payment based upon the number of TennCare enrollees assigned to Unison. The TennCare Bureau reimburses Unison for the cost of providing covered services to TennCare enrollees.

Unison is currently authorized by TDCI and the TennCare Bureau to operate in the community service areas of Shelby County, Northwest Tennessee and Southwest Tennessee which comprise the West Grand Region. All premium revenue earned by Unison is from payments received for enrollees assigned by the TennCare Bureau. As of June 30, 2005, Unison reported enrollment of approximately 50,500 TennCare members.

C. Claims Processing Not Performed by Unison

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy
- Behavioral Health

During the period under examination, Unison subcontracted with the following vendors for the processing and payment of related claims submitted by providers:

- UAS, for medical claims processing
- Davis Vision, Inc., for vision services

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were the financial and compliance deficiencies cited in the examination by TDCI and the Comptroller for the period January 1, 2003, through December 31, 2003:

A. Financial Deficiencies

1. BHP should improve the methodology utilized for the allocation of management fees to NAIC expense categories by initially identifying salaries and compensation incurred by the management company which are 100% related to BHP or other affiliates. Salaries and compensation that are related 100% to a plan should be allocated to the specific plan before other pertinent ratios are applied. Any change to the methodology will not affect reported net income or net worth but the improved methodology will provide a more accurate representation of administrative expense on NAIC financial statements.

2. The following deficiencies were noted in BHP's Supplemental TennCare Operations Statement (Report 2A) for the period ended December 31, 2003.

   - No amounts were reported in the line items for "Copayments" and "Subrogation and Coordination of Benefits." The recovery amounts related to these line items were incorrectly netted against other medical expense categories.

   - Premium tax reimbursements have not been included as a component of premium revenue. Additionally, premium tax payments related to the non-risk period have not been reported as premium tax expense.

   The deficiencies of Report 2A will not affect BHP's reported net income or net worth as of December 31, 2003; however, Report 2A should present BHP's operations as if BHP were still operating at risk.

These findings are not repeated in this report.

B. Compliance Deficiencies

1. The following deficiencies were noted during review of provider complaints:

- As of examination fieldwork, BHP did not have written policies and procedures to process provider complaints.

- The provider complaint log lacks the following elements: nature of the claim dispute, claim resolution, and indication of provider notification.

2. As of examination fieldwork, BHP had not submitted its provider manual to TDCI for review and approval. BHP's provider agreements reference BHP's provider manual for written guidelines as it pertains to standards for care, utilization review/quality improvement, claims processing and other procedural requirements. These references incorporate the provider manual into the provider agreements, and therefore the provider manual requires prior approval in accordance with Tenn. Code Ann. § 56-32-203(c)(1).

3. During testing of financial requirements of the CRA, it was discovered that two provider agreements were amended, yet the amendments were not submitted for prior approval to TDCI before implementation. One of the provider agreements had been amended four times, without prior approval as required by Tenn. Code Ann. § 56-32-203(c)(1).

Findings 1 and 3 are not repeated in this report. Finding 2 is repeated in this report.

V. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The detail of testing as well as management's comments to each finding can be found in Sections VI, VII, and VIII of this examination report.

A. Financial Deficiencies

There were no deficiencies discovered during the limited scope financial examination for the period January 1, 2005 through June 30, 2005.

B. Claims Processing Deficiencies

1. Unison was not in compliance with prompt pay requirements for the month of January 2005. Unison self-reported this occurrence in the January 2005 prompt pay data submission. (See Section VII. A.)

2. The claims processed by Davis Vision were not included in the monthly data files submitted to TDCI to determine prompt pay compliance.

Subsequent to field work Unison submitted the claims processed by Davis Vision, and the calculation of prompt pay percentages were adjusted. (See Section VII.A.)

3. The following deficiencies were noted during the review of Unison's preparation procedures for the claims payment accuracy reports:

   - Davis Vision claims are not included in the claims payment accuracy testing or reporting.

   - The work papers for the third quarter 2005 Claims Payment Accuracy Reporting do not leave a sufficient audit trail because the "Results for each attribute tested for each claim selected" was not maintained for inspection.

   (See Section VII.C.)

4. For the 60 claims tested, one claim paid the incorrect rate because of a manual error. (See Section VII.G.)

5. The following deficiencies were noted during the review of the copayment accumulation procedures:

   - Five enrollees that were charged copays were selected for testing. For one enrollee, the system incorrectly indicated $995 in accumulated copays was applied to the member. However, the actual accumulated amount should have been zero. The Plan indicated that this was due to manual errors.

   - Unison did not provide evidence that during the examination period copayment accumulator files from the TennCare Bureau are properly considered when processing TennCare claims. Without the consideration of the copayment accumulators from TennCare, Unison could have improperly processed claims by applying copays even though the enrollee has exceeded the out-of-pocket maximum limit.

   (See Section VII.H.)

C. <u>Compliance Deficiencies</u>

1. For 8 of the 10 provider complaints tested, Unison did not notify the provider within 30 days the status of the appeal as required in Unison's internal written policies and procedures. Unison's written policies and

procedures agree with Tenn. Code Ann. § 56-32-226. However, the appeal procedures in Unison's unapproved provider manual do not agree with either Unison's internal written policies and procedures or Tenn. Code Ann. § 56-32-226. (See Section VIII.A.)

2. As noted in the previous exam report for the period January 1, 2003 through December 31, 2003, BHP/Unison had not submitted its provider manual to TDCI for prior approval. An unapproved provider manual was provided to TDCI during the current examination field work. A review of this provider manual found an item which did not agree with current written policies and procedures (i.e., policies and procedures regarding provider appeals). On November 23, 2005, Unison submitted sections of the provider manual referenced in the provider agreements only for the purpose of obtaining approval of the provider agreements. Unison has indicated that the provider manual is currently under revision. On November 28, 2005, TDCI sent Unison Notices of Filing Approval for the various provider agreements and additionally requested Unison to submit the revised provider manual when it is completed, and notify TDCI when the revised copy is placed on the Plan's website. (See Section VIII.B.)

3. One of the two subcontracts for physician credentialing was not submitted to TDCI for prior approval as a material modification to Unison's Application for Certificate of Authority**.** (See Section VIII.E.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, Unison is required to file annual and quarterly NAIC financial statements in accordance with NAIC and statutory guidelines with TDCI. The department uses the information filed on these reports to determine if Unison meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At June 30, 2005, Unison reported $5,433,736 in admitted assets, $709,855 in liabilities and $4,723,881 in capital and surplus on its NAIC quarterly

statement. Unison reported total net income of $199,609 on its statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires Unison to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

2005 Statutory Net Worth Calculation

Unison's premium revenue per documentation obtained from the TennCare Bureau totaled $63,987,314 for the calendar year 2004; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), Unison's statutory net worth requirement for the calendar year 2005 is $2,559,493. Since the inception of the TennCare contract on July 1, 2001, Unison has been required to maintain an enhanced net worth of $2,956,800. Unison reported total capital and surplus of $4,723,881 as of June 30, 2005, which is $1,767,081 in excess of the enhanced net worth requirement.

Premium Revenue for the Examination Period

For the examination period January 1 through June 30, 2005, the following is a summary of Unison's premium revenue as defined by Tenn. Code Ann. § 56-32-212(a)(2):

Administrative fee payments from the TennCare Bureau for the period January 1 through June 30, 2005	$4,013,951
Reimbursement for covered services from the TennCare Bureau for the period January 1 through June 30, 2005	31,829,700
Reimbursement for premium tax payments from the TennCare Bureau for the period January 1 through June 30, 2005	701,851
Total premium revenue January 1 through June 30, 2005	$36,545,502

2. Restricted Deposit

Tenn. Code Ann. § 56-32-212(b)(2) and (3) requires all HMOs licensed in the state to maintain a deposit equal to $900,000, plus an additional $100,000 for each $10 million or fraction thereof of annual premium revenue in excess of $20 million and less than $100 million as reported on the most recent annual financial statement filed with TDCI, plus $50,000 for each $10 million or fraction thereof of annual premium revenue in excess of $100 million. As previously noted, Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..."

Based upon premium revenues for calendar year 2004 totaling $63,987,314, Unison's statutory deposit requirement at June 30, 2005, is $1,400,000. Unison has on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $1,400,000 have been pledged for the protection of the enrollees in the State of Tennessee. Subsequently, an amendment to the CRA as of July 1, 2005, changed the deposit requirements to equal the calculated statutory net worth based upon Tenn. Code Ann. § 56-32-212(a)(2). Unison increased the deposits pledged for the protection of the enrollees in the State of Tennessee to $2,600,000 to comply with the CRA.

3. Management Agreement and Administrative Expense Allocations

As previously mentioned, Unison has contracted UAS to provide management services. Effective August 2002, the management fee paid to UAS was 95% of the administrative fees earned by Unison under the TennCare program. The management agreement defines that all expenses to administer the terms of the CRA shall be paid by UAS. The management fee paid by Unison to UAS is not detrimental to the financial stability of the plan. The change to the management agreement had been previously approved by TDCI as a material modification to Unison's Certificate of Authority to operate as a HMO.

For NAIC financial statement reporting purposes, the management fee must be apportioned to the administrative expense categories defined on NAIC annual and quarterly financial statements. The NAIC's Statements of Statutory Accounting Principles (SAP) No. 70 requires that expenses under a management contract shall be apportioned to the entities incurring the expense as if the expense has been paid solely by the incurring entity. Based on TDCI's review, Unison is in compliance with SAP No. 70.

4. Tax Allocation Agreement

TRH has made an election to be treated as a Subchapter S Corporation for federal and state income tax purposes with Unison as a qualified Subchapter S subsidiary for federal income tax purposes. As a result of the election, Unison is treated as a division of TRH for income tax purposes and the results of Unison's operations are included in TRH's income tax returns.

Pursuant to a tax allocation agreement with TRH, Unison is required to reimburse TRH for income tax liability it or its owners would incur with respect to Unison's operations. The amount reimbursed is calculated to equal the federal income tax Unison would have paid if it were a C corporation filing a separate income tax return.

TDCI approved this agreement January 15, 2004, with the following conditions:

- All distributions are made from unassigned surplus.

- The distributions are not extraordinary as defined by Tenn. Code Ann. § 56-11-206(b)(2).

- TDCI is notified 10 days prior to any distribution as defined by Tenn. Code Ann. § 56-11-205(e).

- Distributions will be disclosed in item 5 of the annual Form B filing as required by Tenn. Code Ann. § 56-11-203(b).

During the examination period, Unison was in compliance with the agreement dated January 15, 2004.

5. Claims Payable

As of June 30, 2005, Unison reported $229,247 in claims unpaid on the NAIC quarterly statement. This amount represents an estimate of unpaid claims or incurred but not reported (IBNR) for only the "at risk" period ending June 30, 2002. Review of triangle lag report after June 30, 2005, through October 31, 2005, for dates of services before July 1, 2002, determined that the reported claims payable appears reasonable.

B. Administrative Services Only (ASO)

As previously mentioned, effective July 1, 2002, Unison's CRA was amended so that Unison would operate at no financial risk for the cost of medical claims until December 31, 2003. The stabilization period has been extended at least to December 31, 2006.

These types of arrangements are considered "administrative services only" (ASO) by the NAIC. Under the NAIC guidelines for an ASO line of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments; thus, no provisions for IBNR are reflected in the balance sheet for Unison for dates of service after June 30, 2002.

The CRA requires a deviation from ASO reporting guidelines. The required submission of the supplemental TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if Unison were still operating at-risk. Section 2-10.i. of

the CRA requires Unison to provide "an income statement addressing the TennCare operations." Unison provided this information on the Supplemental TennCare Operations Statement, Report 2A.

C. Medical Fund Target

Effective July 1, 2002, the CRA requires Unison to submit a Medical Fund Target (MFT) on a monthly basis. The MFT accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for IBNR claims for ASO plans are not included in the NAIC financial statements, these estimates are required to be included in the MFT. Unison submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for IBNR expenses have been reviewed for accuracy. No discrepancies were noted during the review of documentation supporting the amounts reported on the MFT report.

D. Schedule of Examination Adjustments to Capital and Surplus

There were no examination adjustments to capital and surplus.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1) and Section 2-18. of the CRA. The statute mandates the following prompt payment requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full

satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.

(B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI currently determines compliance with Tenn. Code Ann. § 56-32-226 by testing in three months increments quarterly data file submissions from each of the TennCare MCOs. Each month is tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. If a TennCare MCO fails to meet the prompt pay standards in any of the three months tested, TDCI, at a minimum, will require claims data submissions on a monthly basis for the next three months to ensure the MCO remains compliant.

During the examination it was determined that Unison had not included Davis Vision claims with medical claims processed by UAS in the data file submissions to TDCI. TDCI requested this information, and Unison submitted this information timely on November 30, 2005.

With the inclusion of Davis Vision claims, the adjusted results for January through June 2005 did not change previous determinations of compliance or non-compliance. The previous results of the prompt pay testing have been recalculated as follows:

Unison Medical	Within 30 days	Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
January 2005	88%	99.9%	**NO**
February 2005	99%	100.0%	**YES**
March 2005	99%	100.0%	**YES**
April 2005	97%	100.0%	**YES**

May 2005	99%	100.0%	**YES**
June 2005	99%	100.0%	**YES**

Unison processed claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for claims processing requirements for the months of February 2005, through June 2005. However, Unison did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the month of January 2005. Unison self-reported this event in their January 2005 prompt pay data submission.

Management's Comments

Unison concurs with the Department's finding that prompt pay standards were not met during January 2005. At that time, Unison was addressing system challenges that arose during our implementation of a claims system software upgrade. As the Department noted, Unison self-reported the problem in our prompt pay data submission. In addition, the success of Unison's efforts to address those challenges is demonstrated by the fact that we processed and paid claims in accordance with the required timeframe for each subsequent month examined.

B. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of testing performed on Unison's claims processing system.

The following items were reviewed to determine the risk that Unison had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints or Independent Reviews on file with TDCI related to accurate claims processing
- Adequacy of Unison's monitoring procedures for subcontractors
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims processing accuracy reports
- Review of internal controls

As noted below, TDCI discovered a deficiency in Unison's procedures to test claims payment accuracy. However, the deficiency did not result in an increase in TDCI's substantive testing. (See Section VII.C.2.)

C. Claims Payment Accuracy Report

Section 2-9. of the CRA requires that 97% of claims are paid accurately upon initial submission. Unison is required to submit quarterly a claims payment accuracy report 30 days following the end of each quarter.

Unison reported the following results for the first and second quarters of 2005:

UNISON	Results Reported	Compliance
First Quarter 2005	97.0%	**Yes**
Second Quarter 2005	98.5%	**Yes**

1. Procedures to Review the Claims Payment Accuracy Reporting

The review of the claims payment accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the second quarter claims payment accuracy report. In addition, twenty claims were selected at random by TDCI and the Comptroller from Unison's second quarter 2005 Claims Payment Accuracy report for review. This review included verification that the number of claims selected by Unison constituted an adequate sample to represent the population**.**

The selected claims were reviewed to determine if the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation traced directly to the actual report filed with TennCare. Also, all claims identified in the report with errors were reviewed to ensure the errors have been corrected.

Further, TDCI reviewed Unison's third quarter 2005 Claims Payment Accuracy report to determine if Unison had incorporated the claims processing changes in the CRA effective July 1, 2005.

2. Results of Review of the Claims Payment Accuracy Reporting

The following deficiencies were noted in the claims payment accuracy report:

- Davis Vision claims were not included in the second quarter 2005 claims payment accuracy testing or reporting.

- The work papers for the third quarter 2005 Claims Payment Accuracy Reporting do not leave a sufficient audit trail because the "Results for each attribute tested for each claim selected" was not maintained for inspection.

Management's Comments

Unison concurs with the two matters deemed deficiencies regarding our Claims Payment Accuracy reporting process, i.e. a failure to include claims data from Unison's vision subcontractors, Davis Vision, Inc. and a failure to include documentation as to each attribute tested for each selected claim in the audit work papers.

As to the deficiency noted regarding claims processed by Davis Vision, Unison pays Davis Vision on a capitated basis and conducts a separate annual review of Davis Vision claims/encounters to ensure that Davis Vision complies with all applicable standards, including claims payment requirements. As of the Claims Payment Accuracy report for the fourth quarter of 2005, Unison revised its audit process to include claims paid by all capitated vendors, including Davis Vision.

While Unison's audit work papers did not detail the results for each attribute tested for each claim selected for review during the quarterly audit process for the third quarter of 2005, it should be noted that Unison tested each claim for the required attributes and used an exception only reporting process to identify claims that were not processed in compliance with each required attribute. Unison believes its exception reporting approach generated all accurate results and all data necessary to support those results, however, we have since modified our process and, as of the Claims Payment Accuracy report for the fourth quarter of 2005, a new attribute matrix is part of the work papers.

D. Claims Selected For Testing From Prompt Pay Data Files

Sixty additional claims were selected from the April 2005 prompt pay data files previously submitted to TDCI. For each claim processed, the data files included the date received, date paid, the amount paid, and if applicable, an explanation for denial of payment.

The number of claims selected for testing was not determined statistically. The results of testing are not intended to represent the percentage of compliance or non-compliance for the total population of claims processed by Unison.

To ensure that the April 2005 data files included all claims processed in the month, the total amount paid per the data files was reconciled to the triangle lags and to the general ledger for the respective accounting periods to within an acceptable level.

E. Comparison of Actual Claim with System Claim Data

The purpose of this test is to ensure that the information submitted on the claim was entered correctly in Unison's claims processing system. Attachment XII of the CRA lists the minimum required data elements to be recorded from medical claims and submitted to TennCare as encounter data. Original hard copy claims were requested for the 60 claims tested. If the claim was submitted electronically, the original electronic submission file associated with the claim was requested.

The data elements recorded on the claims were compared to the data elements entered into Unison's claims processing system. No discrepancies were noted between the information submitted on the claims and the data recorded in Unison's system.

F. Adjudication Accuracy Testing

The purpose of adjudication accuracy testing is to determine if claims selected were properly paid, denied, or rejected. For the 60 claims selected, no discrepancies were noted.

G. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts are calculated correctly.

From the 60 claims selected for testing, one claim paid at an incorrect rate. The Plan indicated that this was due to a manual error.

Management's Comments

Unison concurs with the Department's finding that one claim was incorrectly processed and paid due to manual error. Unison notes that occasional errors are inevitable in all systems where manual processing occurs and that it already conducts internal audits to identify and correct such errors. The Unison Claims Department adjusted the claim and recouped the amount from the provider prior to the close of the audit.

H. Copayment Testing

The purpose of testing copayment is to determine if enrollees are subject to out-of-pocket payments for certain procedures, if out-of-pocket payments are within liability limitations, and if out-of-pocket payments are accurately calculated in accordance with Section 2-3.i. and Attachment XI of the CRA.

The following deficiencies were noted:

- Five enrollees that were charged copays were selected for testing. For one enrollee, the system incorrectly indicated $995 in accumulated copays was applied to the member for the examination period. However, the actual accumulated amount should have been zero. The Plan indicated that this was due to manual errors.

- Unison did not provide evidence that during the examination period copayment accumulator files from the TennCare Bureau are properly considered when processing TennCare claims. Without the consideration of the copayment accumulators from TennCare, Unison could have improperly processed claims by applying copays even though the enrollee has exceeded the out-of-pocket maximum limit. Subsequent to the examination period and effective August 1, 2005, the CRA was amended to no longer require the accumulation of copayments by Unison.

Management's Comments

Unison concurs with Department's findings as to two deficiencies in our treatment of copayment accumulators, i.e. a manual error that resulted in an incorrect accumulation of copayments for a member during the examination period and insufficient coordination of internal data with files from the Bureau of TennCare. As to the manual error, Unison again notes that such errors are inevitable in any process that employs manual processes. In addition, no adverse action occurred in this case because no member reached their out of

pocket maximum. As the Department's report notes regarding the coordination with data provided by TennCare, this matter is now moot due to an intervening change in the CRA.

I. Remittance Advice Testing

The purpose of remittance advice testing is to determine whether remittance advices sent to providers accurately reflect the processed claim information in the system.

The examiners requested remittance advices for 10 of the 60 claims selected for testing to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers. No differences were noted between the claims payment per the claims processing system and the related information communicated to the providers.

J. Analysis of Cancelled Checks

The purpose of analyzing cancelled checks is to: (1) verify the actual payment of claims by Unison; and (2) determine whether a pattern of significant lag times exists between the issue date and the cleared date on the checks examined.

The examiners requested cancelled checks for the 10 claims which were also selected for remittance advice testing. Cancelled checks were provided by Unison. The check amounts agreed with the amounts paid per the remittance advice and no pattern of significant lag times between the issue date and the cleared date was noted.

K. Pended and Unpaid Claims Testing

The purpose of analyzing pended claims is to determine if a significant number of claims are unprocessed and as a result a material liability exists for the unprocessed claims.

The October 2005 pended and unpaid data file submission does not indicate the Plan has a significant number of claims exceeding 60 days. No material unrecorded liability exists for claims exceeding 60 days.

L. Electronic Claims Capability

Section 2-9.g. of the CRA states, "The CONTRACTOR shall have in place a claims processing system capable of accepting and processing claims submitted electronically with the exception of claims that require written documentation to justify payment …" The electronic billing of claims allows the MCO to process claims more efficiently and cost effectively.

The Health Insurance Portability and Accountability Act, Title II (HIPAA) requires that all health plans be able to transmit and accept all electronic transactions in compliance with certain standards as explained in the statute by October 15, 2002. The U.S. Department of Health and Human Services extended the deadline until October 15, 2003, for health plans requesting additional time. Failure to comply with the standards defined for the transactions listed can result in the assessment of substantial penalties.

Unison has implemented the necessary changes to process claims per the standards outlined in the HIPAA statutes.

M. Mailroom and Claims Inventory Controls

The purpose for the review of mailroom and claims inventory controls is to determine if procedures by Unison ensure that all claims received from providers are either returned to the provider where appropriate or processed by the claims processing system. The review of mailroom and claims inventory controls included a walk through with mailroom and claims processing personnel. Based on the review, controls in the mailroom and claims inventory controls were adequate.

Ten claims were judgmentally selected from a batch of incoming mail on November 2, 2005, to determine if the claims were entered into the claims processing system with correct received date. All ten claims were entered into the claims processing system with the correct received date.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

For 8 of the 10 provider complaints tested, Unison did not notify the provider within 30 days the status of the appeal as required in Unison's internal written policies and procedures. Unison's written policies and procedures agree with Tenn. Code Ann. § 56-32-226 which states, "The health maintenance

organization must respond to the reconsideration request within thirty (30) calendar days after receipt of the request." However, Unison's unapproved provider manual states, "First level appeals must include all supporting documentation and specify all reasons why the provider believes Better Health's original decision is in error. First level appeals will generally be decided within thirty (30) days of receipt …"

Management's Comments

Unison concurs with the Department's finding that, in 8 of 10 files tested, we did not notify the provider of the appeal status within 30 days of our receipt of the appeal. During the period covered by this examination, Unison reviewed and decided provider appeals within 30 days of receipt of a complaint; however providers would not necessarily receive notice of the decision within that 30 day period. As a result of this examination, Unison immediately modified its provider complaint process to ensure that all provider complaints are decided and notice of the decision is provided within 30 days of receipt of the complaint. Appeals Department personnel were trained regarding this new process, which is now monitored internally.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim.

As noted in the previous exam report for the period January 1, 2003 through December 31, 2003, BHP/Unison had not submitted its provider manual to TDCI for prior approval. An unapproved provider manual was provided to TDCI during the current examination field work. A review of this provider manual found an item which did not agree with current written policies and procedures (i.e., policies and procedures regarding provider appeals). On November 23, 2005, Unison submitted sections of the provider manual referenced in the provider agreements only for the purpose of obtaining approval of the provider agreements. Unison has indicated that the provider manual is currently under revision. On November 28, 2005, TDCI sent Unison Notices of Filing Approval for the various provider agreements and additionally requested Unison to submit the revised provider manual when it is completed, and notify TDCI when the revised copy is placed on the Plan's website.

Management's Comments

Unison does not concur with the Department's assertion that a deficiency exists regarding Unison's Provider Manual. During the previous market examination and in subsequent discussions with personnel in the Department's TennCare oversight Division, Unison was informed that, to the extent the Provider Manual was expressly incorporated by reference in Unison's network participation agreements, the Manual was subject to Department approval. That understanding is consistent with T.C.A. § 56-32-203(b), which requires approval of provider agreements but not provider manuals. After those discussions with the Department, Unison determined that it would not expressly incorporate its Provider Manual by reference in its network participation agreements with providers.

Despite the fact that the Provider Manual is not expressly incorporated by reference in Unison's 2003 approved provider agreements, the Department now cites the use of a Provider Manual that was not approved in advance as a deficiency. The draft report does not cite any provision of the governing statute or the CRA as authority for that requirement. Similarly, no such cite to a statutory or contractual provision requiring Department approval of the Provider Manual was supplied as part of our interaction with the Department's auditors on this issue during the examination.

However, in an effort to address the Department's ongoing concerns on this issue, Unison again engaged in lengthy discussions with the Department's TennCare Oversight Division regarding the Provider Manual. As a result of those discussions, Unison developed and received Department approval for a chapter in its Provider Manual devoted entirely to matters specific to our TennCare managed care product. We also discussed with the TennCare Oversight Division the need for Department review of changes to that chapter, while the more mundane subjects that are routinely covered in the Manual, such as plan contact information, telephone and fax numbers, address requirements, descriptions of various provider services we offer, etc., could be revised without Department review. Unison's revised Provider Manual, which will include this Department approved chapter on TennCare issues, will be provided to the Department's TennCare Oversight Division this month.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and

obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. The minimum contract language requirements include, but are not limited to: standards of care, assurance of TennCare enrollees' rights, compliance with all Federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the CRA between Unison and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of the CRA requires that all provider agreements executed by Unison shall at a minimum meet the 44 current requirements listed in Section 2-18.

Five provider contracts were reviewed to determine compliance with Section 2-18. of the CRA. The provider contracts represented the following types: hospitals, consulting physician, primary care physician, and ancillary. There were no deficiencies noted.

D. Provider Payments

Examiners tested capitation payments to providers during June 2005 to determine if Unison had complied with the payment provisions set forth in its provider agreements.

All capitation payments during June 2005 were made timely in accordance with the approved provider agreements.

E. Subcontracts

The following subcontracts were submitted for prior approval to TDCI: Medical Transport Services, Inc.-Transportation Vendor; UAS, LLC-Outsourcing Agreement; Davis Vision, Inc.-Integrated Delivery System Agreement; and, St. Jude Children's Research Hospital-Delegation of Physician Credentialing Agreement. However, one subcontract for physician credentialing was not submitted to TDCI for prior approval as a material modification to Unison's Application for Certificate of Authority.

Operation by Unison under this agreement is in a manner contrary to information submitted to TDCI to obtain and maintain its certificate of authority to operate as a HMO. The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operation documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Unison's approved management agreement with UAS states that UAS provides all administrative services necessary for Unison to operate as a health plan under the TennCare program. The approved management agreement states, "Such services shall include, but shall not be limited to, claims payments; medical management; utilization review; member services; accounting and reporting; credentialing; facilities management and mail handling; information technology management; marketing; data analysis and reporting and general administrative services." Delegation of physician credentialing to UT Medical Group, Inc., is a change of the organizational documents and should be prior approved by TDCI.

Management's Comments

Unison does not concur with the finding that a delegated credentialing agreement with UT Medical Group required prior approval by the Department. During the market conduct examination, the Department's auditors focused on the delegated credentialing agreement as a provider agreement subject to review and approval under T.C.A. § 56-32-203(b); however, the draft report now cites the failure to obtain approval as a violation of T.C.A. § 56-32-203(c)(1) because UTMG, rather than Unison Administrative Services, will conduct credentials review of certain providers. However, the Department's assertion that the delegation of credentialing constitutes a material change in how Unison's credentialing functions are performed misconstrues the nature of the delegation at issue. The agreement with UTMG provides for detailed involvement by Unison's credentialing staff in the delegated functions. For example:

- Section B.2 provides that Unison will approve the delegate's credentialing policies and procedures.

- Section C.6 provides for periodic audits to ensure that UTMG's processes meet the credentialing standards specified by Unison, various government agencies and the National Committee for Quality Assurance.

- Section B.4 specifies Unison's standards to be employed in assessing the credentials of a physician or other provider proposed for network participation.

In addition, in numerous instances the agreement expressly provides that Unison retains the unfettered discretion to disapprove any provider that was approved by UTMG. For example, see Sections B.1, B.6, B.8, B.11 and C.5.f. Thus, while UTMG may collect certain information and offer a preliminary opinion as to the credentials of any provider, Unison retains sufficient oversight to make the final decision in each case. And, as Unison Administrative Services conducts those oversight functions for the HMO, the delegated credentialing agreement is consistent with, rather than a material modification of, the documents on file with the Department that describe Unison Administrative Services credentialing role. Finally, as is common practice in the industry, Unison's delegation agreement with UTMG is in most respects identical to its delegation agreement with St. Jude's Hospital that was approved by the Department. This similarity provides additional assurances that any required elements are present in the UTMG delegation agreement.

TDCI Rebuttal

Delegation of physician credentialing to UT Medical Group, Inc., is a change of the organizational documents and should be prior approved by TDCI. Therefore, TDCI requests Unison submit the UT Medical Group, Inc., agreement to TDCI for approval.

F. Non-Discrimination Compliance Testing

Section 2-24 of the CRA requires Unison to demonstrate compliance with Federal Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of the American with Disabilities Act of 1990, the Age Discrimination Act of 1975, and the Omnibus Budget Reconciliation Act of1981. Based on discussions with various Unison staff and a review of policies and related supporting documentation, Unison was in compliance with the reporting requirements of Section 2-24 of the CRA.

G. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding

company system or health maintenance organization holding company system shall register with the commissioner…" Unison has complied with this statute.

H. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

Unison's internal audit function is responsible for the development, monitoring and testing of internal controls at Unison. This testing includes the quarterly claims payment accuracy report required by Section 2-9. of the CRA. Unison's Director of Internal Audit reports directly to the Vice President/General Counsel at Unison. The Vice President/General Counsel reports directly to a member of the board of directors.

I. Behavioral Health Organization (BHO) Coordination

Unison was in compliance with Section 2-3.c.2 of the CRA whereby effective July 1, 2002, "claims for covered services with a primary behavioral diagnosis code, defined as ICD 9-CM 290.xx- 319.xx'' are submitted to Unison for timely processing and payment.

Unison is required to refer unresolved disputes between itself and BHO to the State for a decision on responsibility after providing medically necessary services. Unison did not have any ongoing disputes with the BHO.

J. Contractual Requirements for ASO Arrangements

As previously mentioned, effective July 1, 2002, Unison's CRA was amended so that the Plan would operate as an ASO. As a result, the provisions tested below are a requirement for transactions with dates of service after July 1, 2002.

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1. Medical Management Policies

Section 2-2.s of the CRA requires Unison to comply with the following as it relates to the TennCare line of business:

> Agree to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures and medical management policies and procedures as that existed on April 16, 2002, unless otherwise directed or approved by TennCare, and to submit copies of all medical management policies and procedures in place as of April 16, 2002, to the State for the purpose of documenting medical management policies and procedures before final execution of this Amendment.

Unison's management has confirmed compliance with the requirements described above. During testing of claims processing and provider contracts, no deviations to the requirements were noted.

2. Provider Payments

Section 3.10.h.2(b) of the CRA states that Unison "shall release payments to providers within 24 hours of receipt of funds from the State." The first check run issued in November 2005 was selected for testing. Based on TDCI's inspection, Unison has complied with this provision.

3. 1099 Preparation

Section 3-10.h.2(c) of the CRA states that Unison "shall prepare and submit 1099 Internal Revenue Service reports for all providers to whom payment is made." Based on TDCI's review, Unison has complied with this requirement.

4. Interest Earned on State Funds

Section 3-10.h.2(d) of the CRA states interest generated by funds on deposit for provider payments related to the no-risk agreement period shall be the property of the State. Based on TDCI's review, Unison is in compliance with this requirement.

5. Pharmacy Rebates

Section 3-10.h.2(e) of the CRA states that pharmacy rebates collected by

Unison shall be the property of the state. Unison correctly reduced medical reimbursement requests to the TennCare Bureau for the pharmacy rebates received.

6. Recovery Amounts/Third Party Liability

Section 3-10.h.2(f) of the CRA states that third party recoveries and subrogation amounts related to the no-risk agreement period be reduced from medical reimbursement requests to the TennCare Bureau. Unison correctly reduced medical reimbursement requests to the TennCare Bureau for the amounts recovered from third parties.

K. Conflict of Interest

Sections 4-7. of the CRA warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to Unison in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Subsequent to the examination period, Conflict of Interest requirements of the CRA have been expanded to require an annual filing of a TennCare Disclosure of Lobbying Activities Form certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with conflicts of interest requirements of the CRA could result in liquidated damages in the amount of one-hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for including the substance of this clause in all agreements, subcontracts, provider agreements, and any and all agreements that result from the CRA.

Unison demonstrated the following efforts to determine compliance with Conflict of Interest clauses of the CRA:

- The administrative service agreements between UAS and Unison contain the conflict of interest language of the CRA.

- Formalized procedures in the Corporate Compliance Plan indicate that all provider agreements and subcontracts include provisions in the CRA for conflict of interest.

- Annually, employees complete conflict of interest disclosure statements. If the employee has no conflict of interest, Unison requires the employee to note "None" in the certification area by the employee.

- The organizational structure of Unison includes a Chief Compliance Officer who reports directly to the Board of Directors.

- Unison has an internal audit department which reviews any and all inquiries pertaining to conflict of interest and reports findings back to the Board of Directors and the appropriate senior management. Unison's Vice President and General Counsel stated that the Compliance Officer has not noted any violations requiring the Internal Audit Department to perform focused reviews of compliance with the TennCare CRA including the determination of compliance with conflict of interest. TDCI recommends that the Internal Audit Department should schedule future focused reviews of compliance with the TennCare CRA requirements for determination of compliance with conflict of interest.

- Standards for ethical guidelines have been formalized in a Code of Business Conduct for employees.

- A written compliance program has been developed to provide a mechanism to enforce the Code of Business Conduct. The compliance program is presented annually to all employees and is incorporated in new employee orientation. The compliance program includes, but is not limited to, the duties of the Chief Compliance Officer, auditing processes, and procedures to report conflicts of interest. The written procedures include, but are not limited to, a hotline number to report a conflict of interest and remind employees to dial a 9 to get an outside line if they wish to remain anonymous. Also, a web form is available to report conflicts of interest.

- The employee handbook documents the conflict of interest requirements.

Unison and the administrative subcontractor, UAS, have developed procedures to determine compliance with conflict of interest requirements of the CRA. No instances of non-compliance of conflict of interest requirements were noted during examination test work.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of Unison.